Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DOCTORS HOSPITAL AT RENAISSANCE
PO BOX 9705
MCALLEN TX 78502-9705

Respondent Name
Federal Insurance Co

Carrier's Austin Representative Box
Box Number 17

MFDR Tracking Number
M4-12-0857-01

MFDR Date Received
November 14, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Labor Code 134.403"

Amount in Dispute: $171.63

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Enclosed please find a detailed explanation from Corvel regarding the audit of this medical bill. This explanation clearly identifies the how the payment amount for each CPT code was derived. Thus, no additional reimbursement is owed."

Response Submitted by: Downs Stanford PC

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
July 9, 2011	Outpatient Hospital Services	$171.63	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated August 4, 2011

- 59 – Allowance based on Multiple Surgery Guidelines
- B15 – Procedure/Service is not paid separately
- RD7 – Multiple Procedure/1st Procedure
- RD8 – Multiple Procedure (50%0
- RN – Not paid under OPPS; services included in APC rate
- W1 – Workers' Compensation state Fee Schedule Adj.

Explanation of benefits date August 8, 2011
- W1 – Workers' Compensation State Fee Schedule Adj.
- B15 – Procedure/Service is not paid separately
- RD7 – Multiple Procedure/1st Procedure

Explanation of benefits dated September 13, 2011
- 183 – Original payment decision maintained.
- 59 – Allowance based on Multiple Surgery Guidelines
- B15 – Procedure/Service is not paid separately
- RD7 – Multiple Procedure/1st Procedure
- RD8 – Multiple Procedure/2nd Procedure
- RN – Not paid under OPPS; services include in APC rate

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to reimbursement?

Findings

1. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables is not applicable.
2. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
   - Procedure code 36415 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.00. 125% of this amount is $3.75
   - Procedure code 64493 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0207, which, per OPPS Addendum A, has a payment rate of $522.67. This amount multiplied by 60% yields an unadjusted labor-related amount of $313.60. This amount multiplied by the annual wage index for this facility of 0.8847 yields an adjusted labor-related amount of $277.44. The non-labor related portion is 40% of the APC rate or $209.07. The sum of the labor and non-labor related amounts is $486.51. The cost of these services does

not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $486.51. This amount multiplied by 200% yields a MAR of $973.02.

- Procedure code 64494 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 0204, which, per OPPS Addendum A, has a payment rate of $183.78. This amount multiplied by 60% yields an unadjusted labor-related amount of $110.27. This amount multiplied by the annual wage index for this facility of 0.8847 yields an adjusted labor-related amount of $97.56. The non-labor related portion is 40% of the APC rate or $73.51. The sum of the labor and non-labor related amounts is $171.07. The cost of these services does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line, including multiple-procedure discount, is $85.54. This amount multiplied by 200% yields a MAR of $171.08.
- Procedure code J2250 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J7030 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

3. The total allowable reimbursement for the services in dispute is $1,147.85. This amount less the amount previously paid by the insurance carrier of $1,149.53 leaves an amount due to the requestor of $0.00. No additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Signature	Medical Fee Dispute Resolution Officer	April 18, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.